Washington State Health Care Authority

Authorization for Release of Information

Section 1: Information About the Use or Disclosure

I authorize the use or disclosure of personal health information about me or my dependent child(ren)* as described below. I understand that this authorization is voluntary and I may cancel it at any time as described in Section 2.

Enrollee Information

Name _____
First name *Last name* *Middle initial*

I am enrolled in ❑ Basic Health ❑ Public Employees Benefits Board (PEBB) My I.D. number _____

Authorization

❑ I authorize _____ *(person or organization)* to provide information about ❑ me or ❑ my dependent child(ren)* to the Health Care Authority.

Name(s) of dependent child(ren) to provide information on*_____

_____

❑ I authorize the Health Care Authority to provide information about ❑ me or ❑ my dependent child(ren)* to _____ _____ *(person or organization)*.

Name(s) of dependent child(ren) to provide information on*_____

_____

Specific information to be used or disclosed (including dates if needed) _____

_____

Reason for disclosure/purpose of disclosure _____

_____

This authorization will expire on _____
Date or event relating to you or the purpose of this form

*When state law allows parent or guardian to release information.

Section 2: Important Information About Your Rights

I have read and understand the following statements about my rights:

- I may cancel this authorization at any time prior to the expiration date or event noted above by telling the Health Care Authority in writing. The cancellation will not affect any information either received or given by the Health Care Authority before the cancellation notice was received.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits, such as enrollment, treatment, or payment. If I do not sign this form, the Health Care Authority may not release my information to any person or organization except those needed to determine my continued coverage, eligibility, and enrollment, or as allowed by law.
- The person or organization that I authorize to receive information about me or my dependent child(ren)* might share it with another person or organization. I have the right to ask the Health Care Authority to ensure that its employees do not share information about me or my dependent child(ren)* with anyone other than the person or organization noted above without my further authorization. Exceptions may include persons or organizations needed to determine my continued coverage, eligibility, and enrollment, or as allowed by law.
- The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Section 3: Signature

_____ _____
Signature of enrollee or enrollee's representative *Date*
Form must be completed before signing.

_____ _____
Printed name of enrollee's representative *Relationship to enrollee*

Please return completed form to: **If Basic Health member**—Health Care Authority, P.O. Box 42683, Olympia, WA 98504-2683
If PEBB member—Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684
or fax to 360-923-2608